Telehealth/Telemedicine Billing with current RHC Rules & Regulations
May 8, 2020

http://www.ruralhealthclinic.com/

Join the RHC Information Exchange Facebook Group:
https://www.facebook.com/groups/1503414633296362/
Billing For Telehealth Services in Rural Health Clinic
We will be talking mostly about Medicare rules which do not always apply to other payers.

https://www.cchpca.org/resources/covid-19-related-state-actions

He who has the Gold Makes the Rules

Don’t let the tail wag the Dog
Insurance Payment Guidance

Aetna Guidance

Cigna Guidance

United Guidance

Humana Guidance

Create a Cheat sheet using these Excel Files


Revised RHC Medicare Telehealth Billing Guidance
This is Complicated and Ever Changing!!! Law, Regulations, Guidance have different and often conflicted effective dates.

Panelist Question: Should drinking now be allowed on the job?
What does the Section 3704 Enhancing Medicare Telehealth Services for FQHCs and RHCs During Emergency Period Increasing mean for RHCs?

Section 3704 does five things:

- Medicare will pay for telehealth services that are furnished via a telecommunications system by a rural health clinic to an eligible telehealth individual enrolled in Medicare as long as the RHC is not at the same location as the beneficiary.
- Allows rural health clinics to serve as a distant site for telehealth services
- Allows CMS to develop a payment method based upon payment rates that are similar to the national average payment rates for comparable telehealth services under the Medicare Part B physician fee schedule
- Costs associated with telehealth shall not be used to determine the all-inclusive rate
- These provisions are temporary and only in effect during the declared state of National Emergency.

Source: https://www.documentcloud.org/documents/6819239-FINAL-FINAL-CARES-ACT.html
Category 1: Services that are similar to professional consultations, office visits, and office psychiatry services that are currently on the list of telehealth services. In reviewing these requests, we look for similarities between the requested and existing telehealth services for the roles of, and interactions among, the beneficiary, the physician (or other practitioner) at the distant site and, if necessary, the telepresenter, a practitioner who is present with the beneficiary in the originating site. We also look for similarities in the telecommunications system used to deliver the service; for example, the use of interactive audio and video equipment.

Category 2: Services that are not similar to those on the current list of telehealth services. Our review of these requests includes an assessment of whether the service is accurately described by the corresponding code when furnished via telehealth and whether the use of a telecommunications system to furnish the service produces demonstrated clinical benefit to the patient. Submitted evidence should include both a description of relevant clinical studies that demonstrate the service furnished by telehealth to a Medicare beneficiary improves the diagnosis or treatment of an illness or injury or improves the functioning of a malformed body part, including dates and findings, and a list and copies of published peer reviewed articles relevant to the service when furnished via telehealth. Our evidentiary standard of clinical benefit does not include minor or incidental benefits.

On April 30, CMS issued an interim final rule, which becomes effective upon publication in the federal register


The fact that these services can be furnished in a patient’s home or another temporary expansion location that is temporarily provider based to the hospital does not change the requirements that all services furnished by the hospital require an order by a physician or qualified NPP and must be supervised by a physician or other NPP appropriate for supervising the service given their hospital admitting privileges, state licensing, and scope of practice consistent with the requirements in § 410.27. Hospitals should bill for these services as they ordinarily bill for services along with any specific billing requirements for relocating PBDs specific to billing during a COVID-19 PHE as discussed in section II.D. of this IFC (that is, appending the PO modifier for excepted items and services and the PN modifier for nonexcepted services). Information regarding the application of section 603 of the BBA 2015 to relocating PBDs is available in section II.F.4. of this IFC, as well as section II.E. of this IFC.
Rural Health Clinic Information
Telehealth Billing for RHCs
Why Medicare Patients are slow to adopt Telemedicine
Medicare is Falling Behind

Medicare  Commercial Insurance  Medicaid
How Medicare RHC Regulations have slowed the growth of Telehealth

- The Patient must be located at specific originating sites (except during PHE)
- RHCs can not be Distant Sites (except during PHE)
- Telehealth costs are not used to compute the AIR.
Medicare Recognizes Four Types of Telemedicine
(Five if you count Remote Monitoring)

**Telehealth**
1. Audio and Video
2. Expanded to include all areas and all settings
3. Applicable to new and established patients
4. Medicare Copays and deductibles apply however OIG will allow flexibility for providers to reduce or waive fees during the PHE
5. Payment is changed to then non-facility fee schedule if performed in the office (POS 11, Modifier 95 for Part B)
6. Consent to treat does not need to be obtained

**Virtual Check-Ins**
1. Phone Calls & Store & Forward
2. No Geographic or location restrictions
3. Applicable only to established patients (New is Ok during PHE)
4. Medicare Copays and deductibles apply except when treating COVID
5. Consent to treat needs to be obtained
6. Part B codes are G2012 or G2010 & RHCs use G0071

**E-Visits**
1. Patient Portal
2. No Geographic or location restrictions
3. Applicable only to established patients. (New is Ok during PHE)
4. Medicare Copays and deductibles apply except when treating COVID
5. Consent to treat needs to be obtained
6. Individual services need to be initiated by the patient
7. CPT Codes are 99241, 99242, and 99423 for Part B.

**Telephone**
1. Prolonged Phone Calls
2. Part B Codes are 98966–98968 for Non-Physicians and 99441–99443 for physicians
3. Similar to virtual check-ins
4. Physical Therapist, Speech Pathologists, Occupational Therapists
5. Applicable only to established patients (New is Ok during PHE)
6. Medicare Copays and deductibles apply except when treating COVID

RHC
G2025

RHC
G0071

RHC
G0071

RHC
G2025
CMS also released the attached additional guidance on Rural Health Clinic (RHC) and Federally Qualified Health Centers (FQHC) billing and providing additional flexibilities related to the following:

- Additional claims submission and processing instructions
- Information on cost-sharing related to COVID-19 testing
- Additional information on telehealth flexibilities
- Information on provider-based RHCs exemption to the RHC payment limit

Brock Slabach
National Rural Health Association
Sr. Vice-President, Member Services
Leawood KS

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April 30: New and Expanded Flexibilities for Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) During the COVID-19 Public Health Emergency (PHE) MLN Matters Article

A revised MLN Matters Special Edition Article SE20016 on New and Expanded Flexibilities for Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) During the COVID-19 Public Health Emergency (PHE) is available. Learn new information on billing for distant site telehealth services during the COVID-19 PHE, including:

• New telehealth services that can be provided by RHCs and FQHCs, including audio only telephone evaluation and management services

• Revised bed count methodology for determining the exemption to the RHC payment limit for provider-based RHCs
On April 30, 2020 CMS released a revised SE20016 which updated, changed, and clarified information from the April 17, 2020 version.

CMS is backdating some of the guidance – Watch your dates. For example RHCs can bill Telehealth visits starting January 27, 2020 two months before the CARES Act was approved on March 27th allowing RHCs to be Distant Site Providers and 39 days before patient homes were allowed as originating sites on March 6th.
Originating Sites for Telemedicine can now be in urban areas and can be initiated from a patient’s home during the PHE – March 6, 2020
So can RHCs bill for Telehealth services as a distant site starting on January 27th or March 6th?

The statutory language authorizing RHCs and FQHCs as distant site telehealth providers requires that CMS develop payment rates for these services that are similar to the national average payment rates for comparable telehealth services under the PFS. RHCs and FQHCs must use HCPCS code G2025, the new RHC/FQHC specific G code for distant site telehealth services, to identify services that were furnished via telehealth beginning on January 27, 2020, the date the COVID-19 PHE became effective (see https://www.phe.gov/emergency/news/healthactions/phe/Pages/2019-nCoV.aspx).

Note that the changes in eligible originating site locations, including the patient’s home during the COVID-19 PHE are effective beginning March 6, 2020.

Source: Page 2 of Revised SE0016

Practical Application: While an RHC could in theory be a distant site back to January 27, 2020 that patient would have been located at a qualified originating site (not their home) at that time. That scenario is highly unlikely to have ever happen in an independent RHC and extremely rare in a provider-based RHC. So from a practical standpoint, RHCs can go back to March 6, 2020 and bill as a distant site.
### How to Bill Medicare Telehealth Claims from January 27, 2020 to June 30, 2020

<table>
<thead>
<tr>
<th>April 17th Guidance</th>
<th>April 30th Guidance</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPT: Per Telehealth Listing</td>
<td>CPT: G2025</td>
</tr>
<tr>
<td>Modifiers CG &amp; 95</td>
<td>Modifier CG</td>
</tr>
<tr>
<td>Rate: $92</td>
<td>Rate: $92.03</td>
</tr>
<tr>
<td>Payment: AIR</td>
<td>Payment: AIR</td>
</tr>
<tr>
<td>Reprocessed? Yes</td>
<td>Reprocessed? Yes</td>
</tr>
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</table>

Out with the old. In with the new.
<table>
<thead>
<tr>
<th>HCPCS</th>
<th>MOD</th>
<th>DESCRIPTION</th>
<th>STATUS</th>
<th>MEDICARE PAYMENT</th>
<th>WORK RVU</th>
<th>NON-FAC</th>
<th>Facility</th>
<th>Facility</th>
<th>MP</th>
<th>Non-Facility</th>
<th>Facility</th>
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<th>TOTAL</th>
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<td>1.12</td>
<td>1.12</td>
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<td>0.13</td>
<td>3.05</td>
<td>3.05</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>697</td>
<td></td>
<td>Hea care pract tx in place</td>
<td>X</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>698</td>
<td></td>
<td>Benef refuses service, mod</td>
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<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>699</td>
<td></td>
<td>Specimen collect covid-19</td>
<td>X</td>
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<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>700</td>
<td></td>
<td>Spec coll SNF/Lab COVID-19</td>
<td>X</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
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<td>0.00</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>701</td>
<td></td>
<td>Dis site tele svc ARHC/FQHC</td>
<td>X</td>
<td>+ 1.44</td>
<td>1.01</td>
<td>1.01</td>
<td>0.10</td>
<td>2.55</td>
<td>2.55</td>
<td>2.55</td>
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<td></td>
<td></td>
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<tr>
<td>702</td>
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<td>A</td>
<td>0.54</td>
<td>0.48</td>
<td>0.22</td>
<td>0.03</td>
<td>1.05</td>
<td>0.79</td>
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<td></td>
<td>Qual nondem est pt 5-10m</td>
<td>A</td>
<td>0.25</td>
<td>0.08</td>
<td>0.08</td>
<td>0.01</td>
<td>0.34</td>
<td>0.34</td>
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<td>Qual nondem est pt 11-20m</td>
<td>A</td>
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<td>0.14</td>
<td>0.14</td>
<td>0.02</td>
<td>0.60</td>
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<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>705</td>
<td></td>
<td>Qual nondem est pt 21-min</td>
<td>A</td>
<td>0.69</td>
<td>0.22</td>
<td>0.21</td>
<td>0.03</td>
<td>0.94</td>
<td>0.93</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>706</td>
<td></td>
<td>Md mang high risk ex 30</td>
<td>A</td>
<td>1.45</td>
<td>0.99</td>
<td>0.62</td>
<td>0.11</td>
<td>2.55</td>
<td>2.18</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>707</td>
<td></td>
<td>Gene morph study</td>
<td>A</td>
<td>0.51</td>
<td>0.44</td>
<td>0.44</td>
<td>0.05</td>
<td>1.10</td>
<td>1.10</td>
<td></td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>
FQHCs have Different Reporting Rules for January 27, 2020 to June 30, 2020

<table>
<thead>
<tr>
<th>SUBJECT AREA</th>
<th>POLICY DURING COVID-19</th>
<th>POLICY FQHC/RHC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Services</td>
<td>Approximately 180 different codes available for reimbursement if provided via telehealth. List available <a href="https://www.cchpca.org/resources/search?type%5B186%5D=186">HERE</a></td>
<td>Can only provide the services on <a href="https://www.cchpca.org/resources/search?type%5B186%5D=186">THIS</a> list via telehealth and be reimbursed by Medicare.</td>
</tr>
<tr>
<td>Amount of reimbursement</td>
<td>Same as would received if it had been provided in-person (Fee-for-service rate). Some rates for telephone visits have been increased.</td>
<td>$92.03</td>
</tr>
</tbody>
</table>
| Modifiers            | Per the final interim rule, providers are allowed to report POS code that would have been reported had the service been furnished in person so that providers can receive the appropriate facility or non-facility rate and use the modifier “95” to indicate the service took place through telehealth. If providers wish to continue to use POS code 02, they may and it pays the facility rate | For services delivered January 27, 2020 – June 30, 2020  
**RHCs:** Use G2025 with CG modifier. 95 modifier can be appended, but is not required.  
**FQHCs:** Must report 3 HCPCS/CPT codes: (1) the PPS specific payment code; (2) the HCPCS/CPT code that describes the service with the 95 modifier; (3) G2025 with modifier 95  
**Beginning July 1, 2020**  
FQHCs/RHCs: Only submit G2025. RHCs should no longer use CG modifier. |
Payment Rate increased to $92.03 and G2025 must now be used

Payment to RHCs and FQHCs for distant site telehealth services is set at $92.03, which is the average amount for all PFS telehealth services on the telehealth list, weighted by volume for those services reported under the PFS. Because these changes in policy were made on an emergency basis, CMS needs to implement changes to claims processing systems in several stages.

 Claims Requirements for RHCs

For telehealth distant site services furnished between January 27, 2020, and June 30, 2020, RHCs must report HCPCS code G2025 on their claims with the CG modifier. Modifier “95” (Synchronous Telemedicine Service Rendered via Real-Time Interactive Audio and Video Telecommunications System) may also be appended, but is not required. These claims will be paid at the RHC’s all-inclusive rate (AIR), and automatically reprocessed beginning on July 1, 2020, at the $92.03 rate. RHCs do not need to resubmit these claims for the payment adjustment.

Beginning July 1, 2020, RHCs should no longer put the CG modifier on claims with HCPCS code G2025.

RHC Claims for Telehealth Services from January 27, 2020 through June 30, 2020

<table>
<thead>
<tr>
<th>Revenue Code</th>
<th>HCPCS Code</th>
<th>Modifiers</th>
</tr>
</thead>
<tbody>
<tr>
<td>052X</td>
<td>G2025</td>
<td>CG (required) 95 (optional)</td>
</tr>
</tbody>
</table>
Why use the CG Modifier? CMS will not update their system until July 1, 2020, so claims will reject without a CG modifier until that date. CG does not indicate co-insurance or deductible applies so you can use the CS as well if appropriate. There is no Place of Service on a UB-04.

Panelist Input – Will RHCs have to append or refile claims already processed?
How to Bill Medicare Telehealth Claims on and after July 1, 2020

April 17th Guidance

CPT: G2025
Modifiers: None
Rate: $92
Payment: $92
Reprocessed? No

Out with the old

April 30th Guidance

CPT: G2025
Modifier: None
Rate: $92.03
Payment: $92.03
Reprocessed? No

In with the new
Beginning July 1, 2020, RHCs should no longer put the CG modifier on claims with HCPCS code G2025.

<table>
<thead>
<tr>
<th>Revenue Code</th>
<th>HCPCS Code</th>
<th>Modifiers</th>
</tr>
</thead>
<tbody>
<tr>
<td>052X</td>
<td>G2025</td>
<td>95 (optional)</td>
</tr>
<tr>
<td>Assumptions</td>
<td>Settlement Calculation</td>
<td></td>
</tr>
<tr>
<td>-----------------------------</td>
<td>------------------------</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Independent RHC</td>
<td>Provider-Based RHC</td>
</tr>
<tr>
<td>Charge - 99213</td>
<td>$100</td>
<td>$100</td>
</tr>
<tr>
<td>All-Inclusive Rate</td>
<td>$86.31 is the capped rate</td>
<td>$214 is the average rate per Benchmarking reports</td>
</tr>
<tr>
<td>Telehealth Payment Rate</td>
<td>$92.03</td>
<td>$92.03</td>
</tr>
<tr>
<td>Co-Payment</td>
<td>$20</td>
<td>$20</td>
</tr>
<tr>
<td>Receivable/Payable per Visit</td>
<td>NA</td>
<td>NA</td>
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</table>
Revised SE20016

Telehealth Visit for Established Patient occurring from March 6, 2020 through June 30, 2020 in an Independent RHC

What the UB-04 will look like

<table>
<thead>
<tr>
<th>FL 42 Revenue Code</th>
<th>FL43 Description</th>
<th>FL44 HCPCS/CPT</th>
<th>FL45 DOS</th>
<th>FL46 Units</th>
<th>FL47 Total Charge</th>
<th>RHC Payment Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>0521</td>
<td>Established Office Visit</td>
<td>G2025CG</td>
<td>3/06/2020</td>
<td>1</td>
<td>$100</td>
<td>$86.31 (AIR)</td>
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</table>

Simple T-Account

<table>
<thead>
<tr>
<th>Description</th>
<th>Debit</th>
<th>Credit</th>
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<tbody>
<tr>
<td>Charges</td>
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<td>$100.00</td>
</tr>
<tr>
<td>Receipts - Copay</td>
<td>$20.00</td>
<td></td>
</tr>
<tr>
<td>Receipts - Medicare</td>
<td>$69.05</td>
<td></td>
</tr>
<tr>
<td>Contractual Adjustments</td>
<td>$10.95</td>
<td></td>
</tr>
<tr>
<td>Totals</td>
<td>$100.00</td>
<td>$100.00</td>
</tr>
</tbody>
</table>

Reprocessed Claim at $92.03 in July 2020

<table>
<thead>
<tr>
<th>Description</th>
<th>Debit</th>
<th>Credit</th>
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<tbody>
<tr>
<td>Receipts - Medicare</td>
<td>$4.58</td>
<td></td>
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<tr>
<td>Contractual Adjustments</td>
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<td>$4.58</td>
</tr>
<tr>
<td>Receipts - Medicare</td>
<td>$4.58</td>
<td>$4.58</td>
</tr>
</tbody>
</table>

$73.63 ($92.03 \times 0.80) − 69.05 = $4.58
Revised SE20016

Telehealth Visit for Established Patient occurring from January 27, 2020 through June 30, 2020 in a Provider-based RHC

What the UB-04 will look like

<table>
<thead>
<tr>
<th>FL 42 Revenue Code</th>
<th>FL43 Description</th>
<th>FL44 HCPCS/CPT</th>
<th>FL45 DOS</th>
<th>FL46 Units</th>
<th>FL47 Total Charge</th>
<th>RHC Payment Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>0521</td>
<td>Established Office Visit</td>
<td>G2025CG</td>
<td>1/27/2020</td>
<td>1</td>
<td>$100</td>
<td>$214.00 (Mean AIR)</td>
</tr>
</tbody>
</table>

Simple T-Account

Reprocessed Claim at $92.03 in July 2020

<table>
<thead>
<tr>
<th>Description</th>
<th>Debit</th>
<th>Credit</th>
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</thead>
<tbody>
<tr>
<td>Charges</td>
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<td>$100.00</td>
</tr>
<tr>
<td>Receipts - Copay</td>
<td>$20.00</td>
<td></td>
</tr>
<tr>
<td>Receipts - Medicare</td>
<td>$171.20</td>
<td></td>
</tr>
<tr>
<td>Contractual Adjustments</td>
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<tr>
<td>Totals</td>
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<td>$191.20</td>
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<td>Medicare</td>
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<td>Recoupement – Medicare</td>
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<tr>
<td>Totals</td>
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<td>$97.57</td>
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</table>

$171.20 – 73.63 ($92 X .80) = $97.57

Panelist Input – Should Provider-based RHCs hold claims until July 1?
Telehealth Visit for Established Patient occurring from July 1, 2020 through end of PHE in a Rural Health Clinic

What the UB-04 will look like

<table>
<thead>
<tr>
<th>FL 42 Revenue Code</th>
<th>FL43 Description</th>
<th>FL44 HCPCS/CPT</th>
<th>FL45 DOS</th>
<th>FL46 Units</th>
<th>FL47 Total Charge</th>
<th>RHC Payment Rate</th>
</tr>
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<tbody>
<tr>
<td>0521</td>
<td>RHC Telehealth Visit</td>
<td><strong>G2025</strong></td>
<td>7/1/2020</td>
<td>1</td>
<td>$100</td>
<td><strong>$92.03</strong></td>
</tr>
</tbody>
</table>

Simple T-Account

<table>
<thead>
<tr>
<th>Description</th>
<th>Debit</th>
<th>Credit</th>
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<tbody>
<tr>
<td>Charges</td>
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<td>$100.00</td>
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<tr>
<td>Receipts - Copay</td>
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<tr>
<td>Receipts - Medicare</td>
<td>$73.63</td>
<td></td>
</tr>
<tr>
<td>Contractual Adjustments</td>
<td>$6.37</td>
<td></td>
</tr>
<tr>
<td>Totals</td>
<td>$100.00</td>
<td>$100.00</td>
</tr>
</tbody>
</table>
I just got this Car tuned up. Why doesn’t it run
Why you're not getting paid for your RHC Telehealth Claims

Center for Medicare/Medicaid Services
CMS makes the rules and issues them through MLN Matters and similar Transmittals to the MACs and interested parties.

Medicare Administrative Contractor
MAC contract with CMS to pay providers using the guidance and systems provided by CMS

Clearinghouse
Private companies that scrub claims and provide communications links between MACs and providers (RHCs)

Rural Health Clinic
Interprets the rules provided by CMS & the MACS and prepares bills in accordance with their understanding of the guidance

All Four of these entities must be in sync to get a claim paid
Test the system!!! Send one or two test claims and see if they process!
Question: Do we know what will happen to claims already submitted under old guidance? (Ex 99213 with CG and 95 modifiers)

Answer: Great Question. We are waiting for the MACs to provide guidance.
Will RHCs have to append or refile claims already processed?

- We do not have a good answer for this yet. The best advise to hold the claims for now until we get specific guidance from the MACS.
RHCs may bill for Telephone Calls Effective March 1, 2020
Using G2025 with a payment rate of $92.03

**Additional Telehealth Flexibilities**

During the COVID-19 PHE, RHCs and FQHCs can furnish any telehealth service that is approved as a Medicare telehealth service under the PFS. (See [https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes](https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes).) In addition, effective March 1, 2020, these services include CPT codes 99441, 99442, and 99443, which are audio-only telephone evaluation and management (E/M) services. RHCs and FQHCs can furnish and bill for these services using HCPCS code G2025. To bill for these services, at least 5 minutes of telephone E/M service by a physician or other qualified health care professional who may report E/M services must be provided to an established patient, parent, or guardian. These services cannot be billed if they originate from a related E/M service provided within the previous 7 days or lead to an E/M service or procedure within the next 24 hours or soonest available appointment.

Panelists: Can claims already submitted be refilled as corrected claims to get more reimbursement? IE, Cancel all those G0071 claims?
HCPCS Codes for Telephone Visits

Procedure code 99441: Telephone evaluation and management service provided by a physician to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion

Procedure code 99442: Telephone evaluation and management service provided by a physician to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion

Procedure code 99443: Telephone evaluation and management service provided by a physician to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 21-30 minutes of medical discussion
TIMELINE of a Medicare Telephone Visit

Look Back Period
The medical discussion or remote evaluation is for a condition not related to an RHC service provided within the previous 7 days.

The Telephone Visit
Represents at least 5 minutes of communication technology-based or remote evaluation services are furnished by an RHC practitioner to a patient.

Going Forward
*The medical discussion or remote evaluation does not lead to an RHC visit within the next 24 hours or at the soonest available appointment.
CMS Expanded the number of payable Medicare Part B Telehealth services from 191 to 238

https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes
<table>
<thead>
<tr>
<th>Code</th>
<th>Short Description</th>
<th>Status</th>
<th>Can Audits only Interact with the Requirements?</th>
<th>Medicare Payment Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>0053</td>
<td>Psychotherapy</td>
<td>Temporary Addition for the PHE for the COVID-19 Pandemic</td>
<td>Yes</td>
<td>Noncovered service</td>
</tr>
</tbody>
</table>
Question on CPT 90832

- Question: I am assuming counseling codes such as 90832 are not billable via telephone only? Only the E/M telephone codes? Is this correct?

- Answer: CPT 90832 is included on the list of Telehealth codes that can be performed audio only.
Revised SE20016

Telephone Only (CPT Code 99443) Visit for Established Patient occurring from March 1, 2020 through June 30, 2020 in an Independent RHC

A visit for a telephone only involving CPT code 99443, during the period of March 1, 2020 through June 30, 2020, occurred in an independent RHC.

What the UB-04 will look like

<table>
<thead>
<tr>
<th>FL 42 Revenue Code</th>
<th>FL43 Description</th>
<th>FL44 HCPCS/CPT</th>
<th>FL45 DOS</th>
<th>FL46 Units</th>
<th>FL47 Total Charge</th>
<th>RHC Payment Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>0521</td>
<td>Established Office Visit</td>
<td>G2025CG</td>
<td>3/01/2020</td>
<td>1</td>
<td>$100</td>
<td>$86.31 (AIR)</td>
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</tbody>
</table>

Simple T-Account

<table>
<thead>
<tr>
<th>Description</th>
<th>Debit</th>
<th>Credit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Charges</td>
<td></td>
<td>$100.00</td>
</tr>
<tr>
<td>Receipts - Copay</td>
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</tr>
<tr>
<td>Receipts - Medicare</td>
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<tr>
<td>Totals</td>
<td>$100.00</td>
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</table>

Reprocessed Claim at $92.03 in July 2020

<table>
<thead>
<tr>
<th>Description</th>
<th>Debit</th>
<th>Credit</th>
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</thead>
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<tr>
<td>Receipts - Medicare</td>
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<tr>
<td>Contractual Adjustments</td>
<td>$4.58</td>
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</tr>
</tbody>
</table>

$73.63 ($92.03 x .80) – 69.05 = $4.58
Telephone Only Visit (99441) only Telehealth Visit occurring from July 1, 2020 through end of PHE in a Rural Health Clinic

What the UB-04 will look like

<table>
<thead>
<tr>
<th>FL 42 Revenue Code</th>
<th>FL43 Description</th>
<th>FL44 HCPCS/CPT</th>
<th>FL45 DOS</th>
<th>FL46 Units</th>
<th>FL47 Total Charge</th>
<th>RHC Payment Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>0521</td>
<td>RHC Telehealth Visit</td>
<td>G2025</td>
<td>7/1/2020</td>
<td>1</td>
<td>$50</td>
<td>$92.03</td>
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Simple T-Account

<table>
<thead>
<tr>
<th>Description</th>
<th>Debit</th>
<th>Credit</th>
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<tbody>
<tr>
<td>Charges</td>
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<td>$50.00</td>
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<tr>
<td>Receipts - Copay</td>
<td>$10.00</td>
<td></td>
</tr>
<tr>
<td>Receipts - Medicare</td>
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<tr>
<td>Contractual Adjustments</td>
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<tr>
<td>Totals</td>
<td>$83.60</td>
<td>$83.60</td>
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Changes to G0071 during the State of Emergency

Medicare Virtual Communication and E-visits*
Interactive Technology-based Services

Fee for Service
G2010
G2012
99421
99422
99423

Rural Health Clinic
G0071
with temporary increase in reimbursement

*These are NOT codes for “full-on” Audio/Video Telehealth/Telemedicine Services. We do NOT have billing guidance from CMS on how to bill distant site services yet. You may provide distant site E & M as of 03/27/2020 but the claims cannot drop yet. Distant site services will not pay the AIR and should not be billed as regular RHC encounters. CMS will issue new guidance.

inQuiseek LLC Consulting
Virtual Visits billable for RHCs since January 1, 2019

New Virtual Communication Services

Effective January 1, 2019, RHCs can receive payment for Virtual Communication services when at least 5 minutes of communication technology-based or remote evaluation services are furnished by an RHC practitioner to a patient who has had an RHC billable visit within the previous year, and both of the following requirements are met:

- The medical discussion or remote evaluation is for a condition not related to an RHC service provided within the previous 7 days, and
- The medical discussion or remote evaluation does not lead to an RHC visit within the next 24 hours or at the soonest available appointment.

To receive payment for Virtual Communication services, RHCs must submit an RHC claim with HCPCS code G0071 (Virtual Communication Services) either alone or with other payable services. Payment for G0071 is set at the average of the national non-facility PFS payment rates for HCPCS code G2012 (communication technology-based services) and HCPCS code G2010 (remote evaluation services) and is updated annually based on the PFS national non-facility payment rate for these codes. See Virtual Communication Services Frequently Asked Questions (PDF)

RHC face-to-face requirements are waived when these services are furnished to an RHC patient, and coinsurance and deductibles apply.

Can be a new patient during the National emergency

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/VCS-FAQs.pdf
Virtual Check-In

Does the patient need to be seen?

Yes

Can I bill?

No

No, as it is considered that the virtual check is led to a visit or procedure within the next 24 hours or soonest appointment available.

Can I bill?

Yes OR No

Is this an established patient?

Yes

Is this related to an E/M service provided in the last 7 days?

Yes

You cannot bill.

No

Yes, you can bill.

No

Can I bill?

Is this related to an E/M service provided in the last 7 days?

Yes

You cannot bill.

No

Yes, you can bill.

G2012: Brief discussion (5-10 minutes) with the patient as a communication technology-based service

G2010: Evaluation of a recorded video or images submitted by the patient which includes interpretation and follow up with that patient within 24 business hour

G0071: Virtual check-in for an FQHC/RHC; but similar to G2012

CPT code 99441-99443 (as of 3/30/20) for physicians, NPs, PAs (not POS 02)

99441: A telephone evaluation and management service provided by a physician to an established patient not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion

CPT code 99966-99968 (as of 3/30/20) for other qualified HCP’s (not POS 02)

99966: Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion
Look Back Period

The medical discussion or remote evaluation is for a condition not related to an RHC service provided within the previous 7 days.

The Virtual Visit

Represents at least 5 minutes of communication technology-based or remote evaluation services are furnished by an RHC practitioner to a patient.

Going Forward

*The medical discussion or remote evaluation does not lead to an RHC visit within the next 24 hours or at the soonest available appointment.
RHCS use CPT Code G0071 to report these five CPT Codes

RHCs will be paid $24.76 during the PHE

- G2010: Store & Forward
- G2012: Telephone
- 99421: Portal
- 99422: Portal
- 99423: Portal
Revisions to the G0071 Code Before March 1, 2020

**Part B**
- **G2010**
  - Store and Forward evaluation of video or images
  - Minutes: 5-10 - $12.24

- **G2012**
  - Brief communication technology-based service
  - Minutes: 5-10 - $14.80

**Part A - RHC**
- **G0071**
  - Medicare payment rate was $13.53
  - No Place of service on UB-04
  - Revenue Code: 0521
  - No CG Modifier

Each code is up to 7 days cumulative time
Revisions to the G0071 Code **effective** March 1, 2020

CMS adds three additional CPT Codes to G0071 in addition to G2020 & G2012

**Part B**

99421
• Online digital E & M
• Minutes: 5-10 - $15.52

99422
• Online digital E & M
• Minutes: 11-20 - $31.04

99423
• Online digital E & M
• Minutes: 21+ - $50.16

**Part A - RHC**

G0071

Medicare Revised the payment rate to $24.76

No Place of service on UB-04

Revenue Code: 0521

No CG Modifier

Each code is up to 7 days cumulative time

How to Bill Medicare for G0071

1. Claim Form
   UB-04 (ANSI 837I)

2. Bill Type
   0711

3. Revenue Code
   0521
   0529?

4. HCPCS Code
   G0071

5. Payment
   $24.76

CR modifier (catastrophic/disaster related) to designate any service line item on the claim that is disaster/emergency related is **not** required.

<table>
<thead>
<tr>
<th>Rev Code</th>
<th>Description</th>
<th>HCPCS Code</th>
<th>DOS</th>
<th>Units</th>
<th>Charge</th>
</tr>
</thead>
<tbody>
<tr>
<td>521</td>
<td>Virtual Visit</td>
<td>G0071</td>
<td>3/1/2020</td>
<td>1</td>
<td>$24.76</td>
</tr>
</tbody>
</table>
G0071 Code Date of Service Prior to March 1, 2020

<table>
<thead>
<tr>
<th>FL 42</th>
<th>FL43</th>
<th>FL44</th>
<th>FL45</th>
<th>FL46</th>
<th>FL47</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rev Code</td>
<td>Description</td>
<td>HCPCS Code</td>
<td>DOS</td>
<td>Units</td>
<td>Charge</td>
</tr>
<tr>
<td>521</td>
<td>Virtual Visit</td>
<td>G0071</td>
<td>2/28/2020</td>
<td>1</td>
<td>$13.53</td>
</tr>
</tbody>
</table>
YOU KNOW WHAT WE NEED TODAY?

ANOTHER MODIFIER
CS Modifier effective March 18, 2020 applies to co-insurance related to furnishing or administration of a COVID-19 test or the evaluation of a patient of determining the need for such a test

**Cost-sharing Related to COVID-19 Testing**

For services furnished on March 18, 2020 through the duration of the COVID-19 PHE, CMS will pay all of the reasonable costs for specified categories of evaluation and management (E/M) services if they result in an order for or administration of a COVID-19 test and relate to the furnishing or administration of such test or to the evaluation of an individual for purposes of determining the need for such test. This would include applicable telehealth services. (See MLN Matters article [SE20011](#) for more information.) For the specified E/M services related to COVID-19 testing, including when furnished via telehealth, RHCs and FQHCs must waive the collection of co-insurance from beneficiaries. For services in which the coinsurance is waived, RHCs and FQHCs must put the “CS” modifier on the service line. RHC and FQHC claims with the “CS” modifier will be paid with the coinsurance applied, and the Medicare Administrative Contractor (MAC) will automatically reprocess these claims beginning on July 1, 2020. Coinsurance should not be collected from beneficiaries if the coinsurance is waived.
Coinsurance and Deductible Waived – CS Modifier Announced 4/7/2020

- Families First Coronavirus Response Act Waives Coinsurance and Deductibles for Additional COVID-19 Related Services

The Families First Coronavirus Response Act waives cost-sharing under Medicare Part B (coinsurance and deductible amounts) for Medicare patients for COVID-19 testing-related services. These services are medical visits for the HCPCS evaluation and management categories described below when an outpatient provider, physician, or other providers and suppliers that bill Medicare for Part B services orders or administers COVID-19 lab test U0001, U0002, or 87635.

Telehealth Visit for Established Patient occurring from January 27, 2020 through June 30, 2020 in an Independent RHC  
And the Visit is to treat COVID-19 or to Rule out COVID-19  
What the UB-04 will look like

<table>
<thead>
<tr>
<th>FL 42 Revenue Code</th>
<th>FL43 Description</th>
<th>FL44 HCPCS/CPT</th>
<th>FL45 DOS</th>
<th>FL46 Units</th>
<th>FL47 Total Charge</th>
<th>RHC Payment Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>0521</td>
<td>Established Office Visit</td>
<td>G2025CGCS</td>
<td>1/27/2020</td>
<td>1</td>
<td>$100</td>
<td>$86.31 (AIR)</td>
</tr>
</tbody>
</table>

Simple T-Account

**Debit** | **Credit**
---|---
Charges | $100.00
Receipts - Copay | $0
Receipts - Medicare | $86.31
Contractual Adjustments | $13.69
Totals | $100.00

**Reprocessed Claim at $92.03 in July 2020**

**Debit** | **Credit**
---|---
Receipts - Medicare | $5.72
Contractual Adjustments | $5.72
Receipts - Medicare | $5.72

$92.03 – 86.31 = $5.72
CS Modifier Effective March 18, 2020

When
COVID-19 testing-related services, which are medical visits that are furnished between March 18, 2020 and the end of the Public Health Emergency (PHE)

Where
Office and other outpatient services, Hospital observation services, Emergency department services, Nursing facility services, Domiciliary, rest home, or custodial care services, Home services, Online digital evaluation and management services, RHCs

What
CS Modifier waives cost-sharing under Medicare Part B (coinsurance) for Medicare patients for COVID-19 testing-related services – Provider paid 100% of rate instead of 80%

How
Add the CS modifier along with the CG Modifier to the UB-04 Claim & refile or append claims already filed dated with starting with DOS of 3/18/20 till the end of the PHE

Reference
Can CS be used broadly or are there a very narrow range of ICD-10 codes?

CMS is interpreting this very narrowly and have specific ICD-10 codes that must be on the claim


ICD-10-CM Official Coding and Reporting Guidelines
April 1, 2020 through September 30, 2020

1. Chapter 1: Certain Infectious and Parasitic Diseases (A00-B99)
   
g. Coronavirus Infections

1) COVID-19 Infections (Infections due to SARS-CoV-2)

   a) Code only confirmed cases
   Code only a confirmed diagnosis of the 2019 novel coronavirus disease (COVID-19) as documented by the provider, documentation of a positive COVID-19 test result, or a presumptive positive COVID-19 test result. For a confirmed diagnosis, assign code U07.1, COVID-19. This is an exception to the hospital inpatient guideline Section II. H. In this context, “confirmation” does not require documentation of the type of test performed; the provider’s documentation that the individual has COVID-19 is sufficient.

   Presumptive positive COVID-19 test results should be coded as confirmed. A presumptive positive test result means an individual has tested positive for the virus at a local or state level, but it has not yet been confirmed by the Centers for Disease Control and Prevention (CDC). CDC confirmation of local and state tests for COVID-19 is no longer required.

   If the provider documents "suspected," "possible," "probable," or "inconclusive" COVID-19, do not assign code U07.1. Assign a code(s) explaining the reason for encounter (such as fever) or Z20.828, Contact with and (suspected) exposure to other viral communicable diseases.

   b) Sequencing of codes
   When COVID-19 meets the definition of principal diagnosis, code U07.1, COVID-19, should be sequenced first, followed by the appropriate codes for associated manifestations, except in the case of obstetrics patients as indicated in Section I.C.15.s. for COVID-19 in pregnancy, childbirth, and the puerperium.

   For a COVID-19 infection that progresses to sepsis, see Section I.C.1.d. Sepsis, Severe Sepsis, and Septic Shock

   See Section I.C.15.s. for COVID-19 in pregnancy, childbirth, and the puerperium

   c) Acute respiratory illness due to COVID-19

   (i) Pneumonia
   For a pneumonia case confirmed as due to the 2019 novel coronavirus (COVID-19), assign codes U07.1, COVID-19, and J12.89, Other viral pneumonia.

   (ii) Acute bronchitis
   For a patient with acute bronchitis confirmed as due to COVID-19, assign codes U07.1, and J20.8, Acute bronchitis due to other specified organisms.

   Bronchitis not otherwise specified (NOS) due to COVID-19 should be coded using code U07.1 and J40, Bronchitis, not specified as acute or chronic.

   (iii) Lower respiratory infection
   If the COVID-19 is documented as being associated with a lower respiratory infection, not otherwise specified (NOS), or an acute respiratory infection, NOS, codes U07.1 and J22, Unspecified acute lower respiratory infection, should be assigned.

   If the COVID-19 is documented as being associated with a respiratory infection, NOS, codes U07.1 and J39.8, Other specified respiratory disorders, should be assigned.

   (iv) Acute respiratory distress syndrome
   For acute respiratory distress syndrome (ARDS) due to COVID-19, assign codes U07.1, and J80, Acute respiratory distress syndrome.

   d) Exposure to COVID-19
   For cases where there is a concern about a possible exposure to COVID-19, but this is ruled out after evaluation, assign code Z03.818, Encounter for observation for suspected exposure to other biological agents ruled out.

   For cases where there is an actual exposure to someone who is confirmed or suspected (not ruled out) to have COVID-19, and the exposed individual either tests negative or the test results are unknown, assign code Z20.828, Contact with and (suspected) exposure to other viral communicable diseases. If the exposed individual tests positive for the COVID-19 virus, see guideline a).

   e) Screening for COVID-19
   For asymptomatic individuals who are being screened for COVID-19 and have no known exposure to the virus, and the test results are either unknown or negative, assign code Z11.59, Encounter for screening for other viral diseases. For individuals who are being screened due to a possible or actual exposure to COVID-19, see guideline d).

   If an asymptomatic individual is screened for COVID-19 and tests positive, see guideline g).

   f) Signs and symptoms without definitive diagnosis of COVID-19
   For patients presenting with any signs/symptoms associated with COVID-19 (such as fever, etc.) but a definitive diagnosis has not been established, assign the appropriate code(s) for each of the presenting signs and symptoms such as:

   • R05 Cough
   • R06.02 Shortness of breath
   • R09.0 Fever, unspecified
How to bill Telehealth to Medicare Part B, Fee for Service
Telehealth Services in Provider Homes and during Non-RHC Hours
"We are instructing physicians and practitioners who bill for Medicare telehealth services to report the POS code that would have been reported had the service been furnished in person. This will allow our systems to make appropriate payment for services furnished via Medicare telehealth which, if not for the PHE for the COVID-19 pandemic, would have been furnished in person, at the same rate they would have been paid if the services were furnished in person. Given the potential importance of using telehealth services as means of minimizing exposure risks for patients, practitioners, and the community at large, we believe this interim change will maintain overall relativity under the PFS for similar services and eliminate potential financial deterrents to the clinically appropriate use of telehealth. Because we currently use the POS code on the claim to identify Medicare telehealth services, we are finalizing on an interim basis the use of the CPT telehealth modifier, modifier 95, which should be applied to claim lines that describe services furnished via telehealth. We note that we are maintaining the facility payment rate for services billed using the general telehealth POS code 02, should practitioners choose, for whatever reason, to maintain their current billing practices for Medicare telehealth during the PHE for the COVID-19 pandemic."

Page 15 of Interim Final Regulation released March 30, 2020

https://www.cms.gov/files/document/covid-final-ifc.pdf?fbclid=IwAR0TYjcu5xyUfdNF03mb9AFBgKZmw82s7iE9cCpZ67jzjAKUdnR8utuLy_4
Telehealth Part B Billing Changes due to the Public Health Emergency
Per Interim Final Rule published March 30, 2020 applicable beginning March 1, 2020

**PRE-COVID**

- **Time Frame**: February 28, 2020 & before
- **Place of Service**: 02
- **Payment**: Payment was limited to the facility fee payment schedule.

**PHE**

- **Time Frame**: March 1, 2020 to the end of PHE*
- **Place of Service**: Telehealth Services done in the office Use **POS 11 and Modifier 95**.
- **Payment**: Payment will be the Non-Facility Fee

* CMS removed the restriction on originating sites on March 6, 2020
### Place of Service Matters

<table>
<thead>
<tr>
<th>CPT with Description</th>
<th>POS 1</th>
<th>POS 2</th>
<th>Variance</th>
<th>% Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Non-Facility Modifier 95</td>
<td>Facility Modifier 95</td>
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<tr>
<td>99201 OFFICE/OUTPATIENT VISIT NEW</td>
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<td>99202 OFFICE/OUTPATIENT VISIT NEW</td>
<td>$77.23</td>
<td>$51.61</td>
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<tr>
<td>99203 OFFICE/OUTPATIENT VISIT NEW</td>
<td>$109.35</td>
<td>$77.23</td>
<td>-$32.12</td>
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<tr>
<td>99204 OFFICE/OUTPATIENT VISIT NEW</td>
<td>$167.10</td>
<td>$132.09</td>
<td>-$35.01</td>
<td>-21.0%</td>
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<tr>
<td>99205 OFFICE/OUTPATIENT VISIT NEW</td>
<td>$211.13</td>
<td>$172.51</td>
<td>-$38.62</td>
<td>-18.3%</td>
</tr>
<tr>
<td>99211 OFFICE/OUTPATIENT VISIT EST</td>
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<td>99212 OFFICE/OUTPATIENT VISIT EST</td>
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<td>99213 OFFICE/OUTPATIENT VISIT EST</td>
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<td>-$23.82</td>
<td>-31.3%</td>
</tr>
<tr>
<td>99214 OFFICE/OUTPATIENT VISIT EST</td>
<td>$110.44</td>
<td>$80.48</td>
<td>-$29.96</td>
<td>-27.1%</td>
</tr>
<tr>
<td>99215 OFFICE/OUTPATIENT VISIT EST</td>
<td>$148.33</td>
<td>$113.68</td>
<td>-$34.65</td>
<td>-23.4%</td>
</tr>
</tbody>
</table>

**Total:**

- **$1,015.95**
- **$742.73**
- **-$273.22**
- **26.9%**

---

March 30, 2020 Telehealth Part B Billing Guidance
There is no difference in amounts paid to providers for services performed via Telehealth in other settings

<table>
<thead>
<tr>
<th>CPT with Description</th>
<th>Non-Facility Fee</th>
<th>Facility Fee</th>
<th>Variance</th>
<th>% Difference</th>
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<tbody>
<tr>
<td>99231 SUBSEQUENT HOSPITAL CARE</td>
<td>$40.06</td>
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<td>0.0%</td>
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<tr>
<td>99232 SUBSEQUENT HOSPITAL CARE</td>
<td>$73.62</td>
<td>$73.62</td>
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<td>0.0%</td>
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<tr>
<td>99233 SUBSEQUENT HOSPITAL CARE</td>
<td>$106.10</td>
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<td>G0406 INPT/TELE FOLLOW UP 15</td>
<td>$73.26</td>
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<td>G0407 INPT/TELE FOLLOW UP 25</td>
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<td>G0408 INPT/TELE FOLLOW UP 35</td>
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<td>$105.38</td>
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<tr>
<td>G0425 INPT/ED TELECONSULT 30</td>
<td>$101.77</td>
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<tr>
<td>G0426 INPT/ED TELECONSULT 50</td>
<td>$138.22</td>
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<tr>
<td>G0427 INPT/ED TELECONSULT 70</td>
<td>$204.99</td>
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<td>$0.00</td>
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RHC Originating Site Telehealth Billing – Pre-Covid

Example: RHC is originating site and Physician is Distant site

Distant Site Provider (Specialist)
Place of Service 02
CPT Code 99213

$53.33

Originating Site (RHC)
Restricted to Certain Rural Areas
Revenue Code 0780
CPT Code Q3014

$26.15

Total Medicare Payment
Co-pays and Deductibles apply
So payment amount will vary

$79.48
Medicare Part B – (Not RHC) Telehealth Billing – Public Health Emergency

Example: Physician provides Telehealth service while located in office

- $76.15
  - Medicare Part B Provider
  - In a clinic
  - Place of Service 11, Modifier 95
  - CPT Code 99213

- $0
  - No Originating Site
  - Patient can be home
  - Or in urban area

- $76.15
  - Total Medicare Payment
  - Co-pays and Deductibles apply
  - So payment amount will vary

Place of Service Code 02 is no longer used during the PHE unless you want to be paid less.

May 8 – Update – See next slide for updates to the Originating site rules for hospitals
Patient’s home’s may be a temporary expansion site and considered a provider-based department of the hospital

**Telehealth**

- Hospital Outpatient Services Accompanying Professional Services Furnished Via Telehealth: When a physician or nonphysician practitioner who typically furnishes professional services in the hospital outpatient department furnishes telehealth services during the COVID-19 PHE, they bill with a hospital outpatient place of service since that is likely where the services would have been furnished if not for the COVID-19 PHE. The physician or practitioner is paid for the service under the PFS at the facility rate, which does not include payment for resources such as clinical staff, supplies, or office overhead since those things are usually supplied by the hospital outpatient department. During the COVID-19 PHE, if the beneficiary’s home or temporary expansion site is considered to be a provider-based department of the hospital, and the beneficiary is registered as an outpatient of the hospital for purposes of receiving telehealth services billed by the physician or practitioner, the hospital may bill under the PFS for the originating site facility fee associated with the telehealth service.

But the recognition of a patient’s home as an extension of the hospital is not automatic if the hospital is expanding an “excepted” off-campus location (which are those that are not subject to the reduced fee schedule amount under Section 603 of BBA 2015). When doing so, a hospital must send an email to its CMS Regional Office, asking for an “extraordinary circumstances relocation exception.” The email must include the following information:

1. The hospital’s CMS Certification Number (CCN);
2. The address of the hospital’s current provider-based department (PBD);
3. The address of the “relocated PBD.” (Technically, CMS will consider the patient’s home to be a relocated component of the hospital’s outpatient department or “excepted” provider-based facility [see discussion below]);
4. The date the hospital began furnishing services at the new PBD. (In other words, the date the hospital started providing telehealth services to patients at their homes.);
5. A brief justification for the relocation and the role of the relocation in the hospital’s response to the PHE (e.g., to minimize the risk of infection to healthcare workers and other patients);
6. An attestation that the relocation is not inconsistent with the hospital’s state emergency preparedness or pandemic plan.
7. A statement as to why the new PBD location (i.e., the patient’s home) is an appropriate setting for furnishing covered outpatient items and services.

With respect to item 3 above, CMS has stated that a request for each patient’s home must be submitted in order for the location to become a PBD. CMS has indicated that it is working on additional guidance regarding this process, and we will continue to monitor for further details.
Modifiers used in Telehealth Billing

95
Medicare uses this now
Synchronous telemedicine rendered via real-time interactive audio & video

GT
CAH Method II
Used for interactive audio & telemedicine systems. Tells payor that service delivered via telemedicine

CS
Waives Cost Sharing
Waives cost-sharing under Medicare Part B (coinsurance and deductible amounts) for Medicare patients for COVID-19 testing-related services

GO
Acute Stroke
Telehealth service for diagnosis, evaluation or treatment of systems of an acute stroke

GY
ABN
Notice of Liability not issued, not required under payer policy because service is excluded from Medicare benefit.
Elimination of the GT Modifier for Telehealth Services

MLN Matters Number: MM10152
Related Change Request (CR) Number: 10152
Related CR Release Date: November 29, 2017
Effective Date: January 1, 2018
Related CR Transmittal Number: R3929CP
Implementation Date: January 2, 2018

PROVIDER TYPES AFFECTED
This MLN Matters® Article is intended for providers who submit claims to Medicare Administrative Contractors (MACs) for telehealth services provided to Medicare beneficiaries.

PROVIDER ACTION NEEDED
Change Request (CR) 10152 eliminates the requirement to use the GT modifier (via interactive audio and video telecommunications systems) on professional claims for telehealth services. Use of the telehealth Place of Service (POS) Code 02 certifies that the service meets the telehealth requirements.

BACKGROUND
CR10152 reviews the previous guidance that instructed practitioners to submit claims for telehealth services using the appropriate CPT or HCPCS code for the professional service along with the telehealth modifier GT (via interactive audio and video telecommunications systems). The GT modifier is still required when applicable. As a result of the CY 2017 Physician Fee Schedule (PFS) final rule, CR9726 implemented payment policies regarding Medicare's use of a new POS Code 02 to describe services furnished via telehealth. The new POS code became effective January 1, 2017. Use of the telehealth POS code certifies that the service meets the telehealth requirements.

Note that for distant site services billed under Critical Access Hospital (CAH) method II on institutional claims, the GT modifier will still be required.

MACs will apply the "one every three days" frequency edit logic for telehealth services when codes 99231, 99232, and 99233 are billed with POS 02 for claims with dates of service January 1, 2018, and after. This frequency editing also applies when these services are span-dated on the claim (that is, the "from" date and the "to" date of service are not equal, and the "units" field is greater than one).

MACs will apply the existing "one every 30 days" frequency edit logic for telehealth services when codes 99307, 99308, 99309, and 99310 are billed with POS 02 for claims with dates of service January 1, 2018, and after. This frequency editing also applies when these services are span-dated on the claim (that is, the "from" date and the "to" date of service are not equal, and the "units" field is greater than one).

ADDITIONAL INFORMATION

To review the MLN Matters® article 9726 related to this CR you may go to: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM9726.pdf

If you have any questions, please contact your MAC at their toll-free number. That number is available at https://www.cms.gov/Research-Statistics-D ata-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/

DOCUMENT HISTORY

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<th>Description</th>
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<tr>
<td>December 4, 2017</td>
<td>Initial Article Released</td>
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Thank You!!!

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